

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First John	Middle Bentz, Sr.	Lost	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI: DEATH MATED <input type="checkbox"/> 3-30-68 19 1:32 M	2b. HOUR 1:32 M	
3. SEX Male	4. RACE White	S. DATE OF BIRTH 12-7-83	6. AGE (In years lost birthday) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 3-30-68 19 1:40 P M	2d. HOUR 1:40 P M
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bethlehem Steel		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Accident	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D.	
14. FATHER'S NAME First Unknown		Middle	Last	15. MOTHER'S MAIDEN NAME First Unknown		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 174-05-8838A		17. INFORMANT Fred Bentz, R.D., Accident, Md.		ADDRESS	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u></p> <p>4109</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours							
Years							
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p>4201</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
State							
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>James H. Feaster, Jr., M.D.</u></p> <p>EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.</p>							
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22b. DATE SIGNED 3-30-68							
ADDRESS (Street, city, town, or county) <u>Oakland, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/3/68		23c. NAME OF CEMETERY OR CREMATORIAL Monongahela Cemetery		23d. LOCATION (City or Town) North Braddock, Alleghany,	(County) Pa.
24. FUNERAL DIRECTOR Ruth Newman		ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR APR 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

04146

04130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Ella	Middle Josephine	Last Broderick	2a. DATE OF DEATH Month 3	Day 21	Year 68	12 HOUR 25A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 14, 1870		6. AGE (In years last birthday) 97	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett			
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cuppatt-Weeks Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 737 Maryland Ave (Formerly)			
14. FATHER'S NAME F. Roderick D. Fisk	15. MOTHER'S MAIDEN NAME Ella			J.	Reynolds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Helena Schott	Address Box 173 Cresaptown, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>440.9</u> (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4500</u>							
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 3-19-68, 19, that (I) (we) last saw the deceased alive on 3-19-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <u>John H. Feaster, Jr.</u>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-21-68			
22d. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.	22e. ADDRESS 104 S. 2nd. St., Oakland, Md. 21550						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 23, 1968	23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Catholic		23d. LOCATION (City or Town) Frostburg	(County) Allegany	(State) Md.	
24. FUNERAL DIRECTOR <u>John J. Hafner, Jr.</u>	ADDRESS 230 Baltimore Ave Cumberland	25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. Juges</u>			

FOR STATE
HEALTH DEPT. M

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

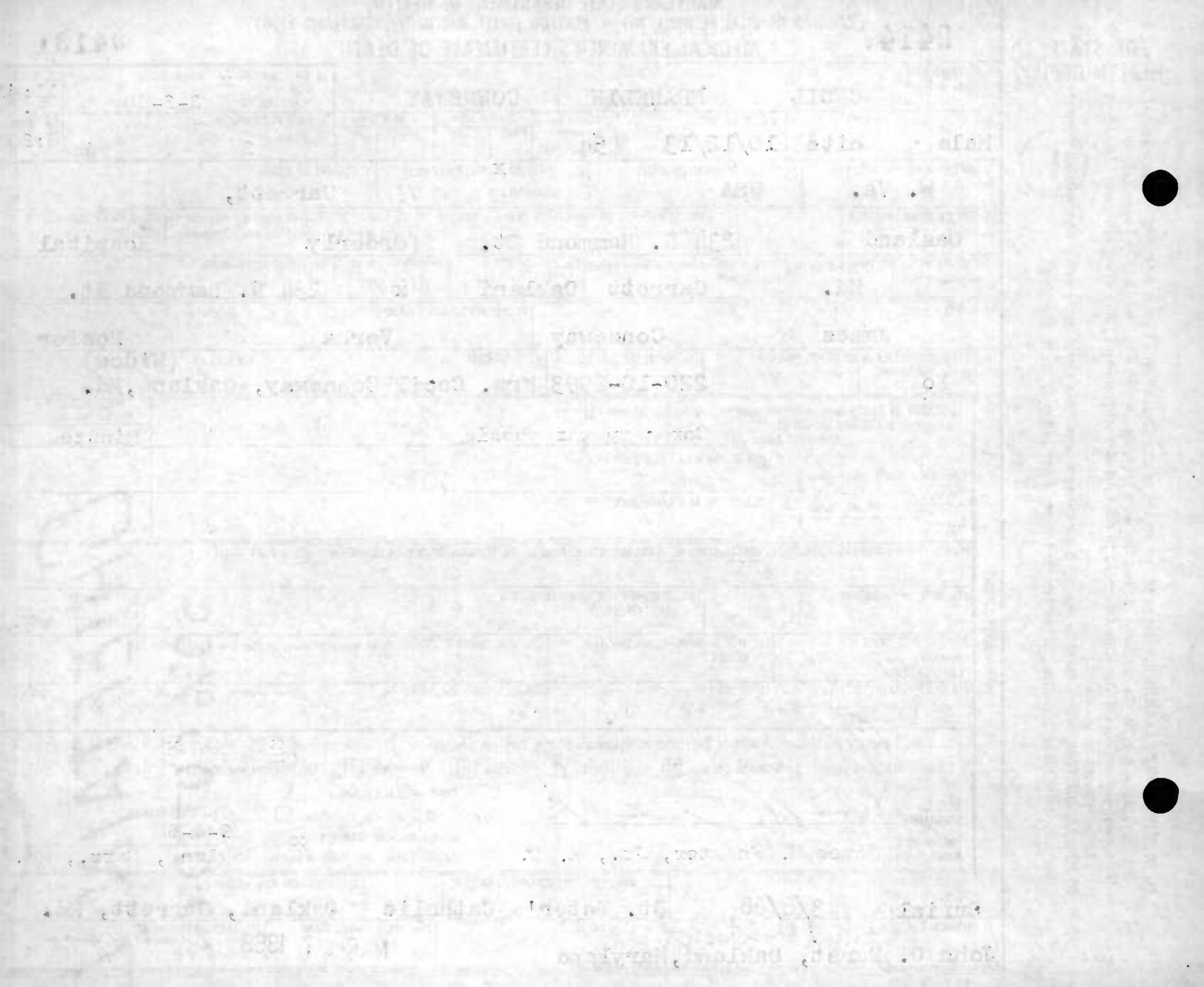
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04131

1. DECEASED NAME (Type or Print)	First CECIL	Middle FRANKLIN	Lost CONNEWAY	2a. DATE KNOWN OF ESTI- DEATH MATED	Month 3-3-68	Day 19	Year 1968	2b. HOUR 11:45 P.M.
3. SEX Male	4. RACE White	S. DATE OF BIRTH 10/12/13	6. AGE (in years and birthday) 54 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3	Day 4	Year 1968
7a. BIRTHPLACE (State or foreign country) W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett,					
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 234 N. Hammond St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Orderly			12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 234 N. Hammond St.				
14. FATHER'S NAME James	First Conneway	Middle	Lost	15. MOTHER'S MAIDEN NAME Verna	First	Middle	Lost Rosier	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-10-2993	17. INFORMANT Mrs. Cecil Conneway, Oakland, Md.	ADDRESS (Widow)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 4129 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> } lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.								
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Oakland, Garr., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/6/68	23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Catholic			23d. LOCATION (City or Town) Oakland, Garrett, Md.	(County)	(State)
24. FUNERAL DIRECTOR John O. Durst		ADDRESS John O. Durst, Oakland, Maryland	25a. REC'D BY REGISTRAR DATE MAR 7 1968			25b. REGISTRAR'S SIGNATURE Charles J. ...		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE
HEALTH DEPT.

04148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	26. HOUR 10:45 A.M.	
Audrey			Ernest Cox			<input checked="" type="checkbox"/>	3-4-68	19			
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS				27. HOUR 10:45 A.M.		
Male	White	3-24-95	72 YRS.								
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH		Md.			
W.Va.		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Garrett					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Oakland			Garrett Co. Mem. Hospital			Farmer			Gen. Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
W.Va.			Ritchie			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD Pullman, W.Va.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Moses			H.	Cox		Margaret					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW I			280-03-6576			Raiguel Funeral Home, Harrisville, WVa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4412 APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF BETWEEN ONSET AND DEATH HOURS											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) RUPTURED ARTERIOSCLEROTIC HOURS last. DUE TO, OR AS A CONSEQUENCE OF (c) ABDOMINAL AORTIC ANEURYSM											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
451X						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>											
22b. DATE SIGNED 3-4-68											
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>											
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3/6/68			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) (County) (State)		
Burial			Pullman Cemetery			Pullman, Ritchie, W.Va.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR DATE MAR 7 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Dugay</i>		
John O. Durst, Oakland, Maryland											

FOR STATE
HEALTH DEPT.



Any delay in filing this form will result in a fine of \$2, and 3 days in jail.

PM 3, Page 2, and 3

with form

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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04151

04136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ELSEY	Middle LLOYD	Lost GLOVER	2a. DATE OF DEATH Month MARCH	Day 31	Year 1968	2b. HOUR 4:20PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MAY 30, 1888		6. AGE (In years last birthday) 79	IF UNDER 1 YEAR MONTHS 10		IF UNDER 24 HRS. DAYS 1
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH GARRETT				
10. CITY OR TOWN OF DEATH OAKLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT COUNTY MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY GARRETT	13c. CITY OR TOWN FRIENDSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER FRIENDSVILLE, MD.			
14. FATHER'S NAME LUCIUS	First Middle GLOVER	15. MOTHER'S MAIDEN NAME AMY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If give war or dates of service) 176-16-1563	17. INFORMANT (WIFE) LAURA E. GLOVER	Address FRIENDSVILLE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436.9				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c)				Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 231X							
19a. DATE OF OPERATION 22	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 3-2-68 19 to MARCH 31, 1968, that (I) (we) last saw the deceased alive on MARCH 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James H. Feaster, Jr., M.D.	22c. DATE SIGNED 3-31-68						
22d. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.	22e. ADDRESS SECOND STREET OAKLAND, MD. 21550						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/3/68	23c. NAME OF CEMETERY OR CREMATORIAL Addison Cemetery	23d. LOCATION (City or Town) Addison, Penna.		(County) (State)		
24. FUNERAL DIRECTOR Gina Janet K. Williams	ADDRESS Kingwood, West Va.	25a. REC'D BY REGISTRAR DATE 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Louis	Middle Hacker	Last	2a. DATE KNOWN X Month Day Year 3-24-68 19	2b. HOUR 2 P M	
3. SEX Male	4. RACE White	S. DATE OF BIRTH 1-15-1888	6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3-24-68 Year 19	2d. HOUR 3P M
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH Garrett		
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cuppett Weeks Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13c. CITY OR TOWN Allegany Lonaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME Henry		Middle Hacker	Last	15. MOTHER'S MAIDEN NAME Martha E. McKenzie	First Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Martha Clark	ADDRESS Lonaconing, Md. (Neice)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9		Coronary thrombosis					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 4201		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease					Years
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old cerebral vascular accident.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-24-68	
James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) Oakland, Md. 21550	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/1968		23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. RECD BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. Feaster	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8-48-2

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 04153			2 04138											
1. DECEASED-NAME (Type or print)			First SARAH		Middle AMELIA		Last HARVEY							
2. DATE OF DEATH March 26, 1968 Noon M			20. DATE OF DEATH March 26, 1968 Noon M		21. DEATH CERTIFIED BY HOSPITAL OR ATTENDING PHYSICIAN TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		22. DEATH CERTIFIED BY ATTENDING PHYSICIAN TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.							
3. SEX Female			4. RACE White		5. DATE OF BIRTH Sept. 27, 1894		6. AGE (In years last birthday) 73 YRS.							
7. BIRTHPLACE (State or foreign country) Maryland			8. CITIZEN OF WHAT COUNTRY? USA		9. COUNTY OF DEATH Garrett		10. CITY OR TOWN OF DEATH Mt. Lake Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		13b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 105					
14. FATHER'S NAME Charles			15. MOTHER'S MAIDEN NAME Buntz		16. SOCIAL SECURITY NO.		17. INFORMANT (Husband) James Harvey, Box 105, Mt. Lake Park,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Disease</i> Year		Address Md.			
19. DATE OF OPERATION 33IX			20. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diabetes Mellitus - Severe</i>		21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work		24. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		25. LOCATION Street or R.F.D. No. City or Town County State			
26. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			27. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		28. SIGNATURE <i>Herbert H. Leighton</i>		29. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		30. ADDRESS Oakland, Maryland		31. DATE SIGNED 27 Mar 68			
32. BURIAL, CREMATION, REMOVAL (Specify) Burial			33. DATE 3/29/68		34. NAME OF CEMETERY OR CREMATORIAL Garr. Co. Mem. Gardens		35. LOCATION (City or Town) Oakland, Garrett, Md.		36. (County) Garrett, Md.		37. (State) Md.			
38. FUNERAL DIRECTOR John O. Durst			39. ADDRESS John O. Durst, Oakland, Maryland		40. REC'D BY REGISTRAR MAR 28 1968		41. REGISTRAR'S SIGNATURE Judge		42. DATE MAR 28 1968					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)		First Baby	Middle Boy	Lost Michaels	2a. DATE OF DEATH Month March	Day 2, 1968	Year 1968	2b. HOUR 2:00 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 1, 1968		6. AGE (In years last birthday) YRS. 17		IF UNDER 1 YEAR MONTHS 40		IF UNDER 24 HRS. HOURS 17		MIN. 40	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett County, Md.							
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER General Delivery					
14. FATHER'S NAME First John		Middle Wesley	Lost Michaels	15. MOTHER'S MAIDEN NAME First Helen		Middle Lucille	Lost Sines						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. - - -		17. INFORMANT John W. Michaels		Address Friendsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>7761</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) By dates, this infant is about 8 weeks premature													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1968</u> , to <u>March 2, 1968</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>March 1, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.													
22b. SIGNATURE <u>Dr. James H. Feaster, Jr.</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3-2-68								
22d. PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr.		22e. ADDRESS Oakland, Maryland 21550											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/3/68		23c. NAME OF CEMETERY OR CREMATORIAL Sand Springs Cemetery		23d. LOCATION (City or Town) Garrett Co.		(County) Maryland		(State)			
24. FUNERAL DIRECTOR Gerald N. Minnick		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR MAR 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. Moore</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04155

34140

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Mt. Lake Park

c. LENGTH OF STAY IN lb

6mon.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Shady Acres

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Edna

Mae

Michaels

4. DATE
OF
DEATH

Month March 29, 1968

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

Female White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

July 8, 1907

9. AGE (In years
last birthday)

60 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Gormania, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank William Cline

14. MOTHER'S MAIDEN NAME

Bertha Stella Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

212-24-2318 Arveta McCrum, Star Rt. Kitzmiller, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2509

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cerebral Hemorrhage

21538
INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

Arteriosclerosis

years

Diabetes Mellitus

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

X MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. at work at work

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1965, to March 1968, that (I) (we) last saw the deceased alive on March 18, 1968, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

Le E Mance

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

30 March

22c. PHYSICIAN'S
NAME (Type)

Dr. Andrew E. Mance

22d. ADDRESS

Oakland, Md. 21550

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

Mar. 31/68

23c. NAME OF CEMETERY OR CREMATORIUM

Kalbaugh Cemetery

23d. LOCATION (City, town or county) (State)

Elk Garden, Mineral Co. W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE

Amy M. Shaylor

Baltimore, W. Va.

P. O. Kitzmiller, Md.

25a. REC'D BY REGISTRAR

Charles J. Judge

DATE APR 3 1968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04156

04141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First John	Middle Thomas	Last Moore	2a. DATE OF DEATH Month March	Day 9	Year 1968	2b. HOUR a 4:30M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 8, 1900			6. AGE (In years last birthday) 67	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Loch Lynn, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH GARRETT						
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trackman			12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Kitzmiller	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER					
14. FATHER'S NAME John Bollen Moore	15. MOTHER'S MAIDEN NAME Daisy Mae Harvey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. WW 2	17. INFORMANT Gertie V. Moore	Address Kitzmiller, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> <i>Coronary Occlusion</i> <i>4 weeks</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b) <i>lesser artery disease</i> <i>years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> <i>years</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i> <i>cardiobronchitis</i>									
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1968</i> , to <i>9 Jan 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. E. Mance</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED March 11, 1968					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS Oakland, Md. 21550								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gardens	23d. LOCATION (City or Town) Oakland, Maryland			(County)		(State)	
24. FUNERAL DIRECTOR <i>Gerald M. Minnich</i>	ADDRESS Oakland, Maryland			25a. REC'D BY REGISTRAR MAR 13 1968	25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>				

Yd. and

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04157

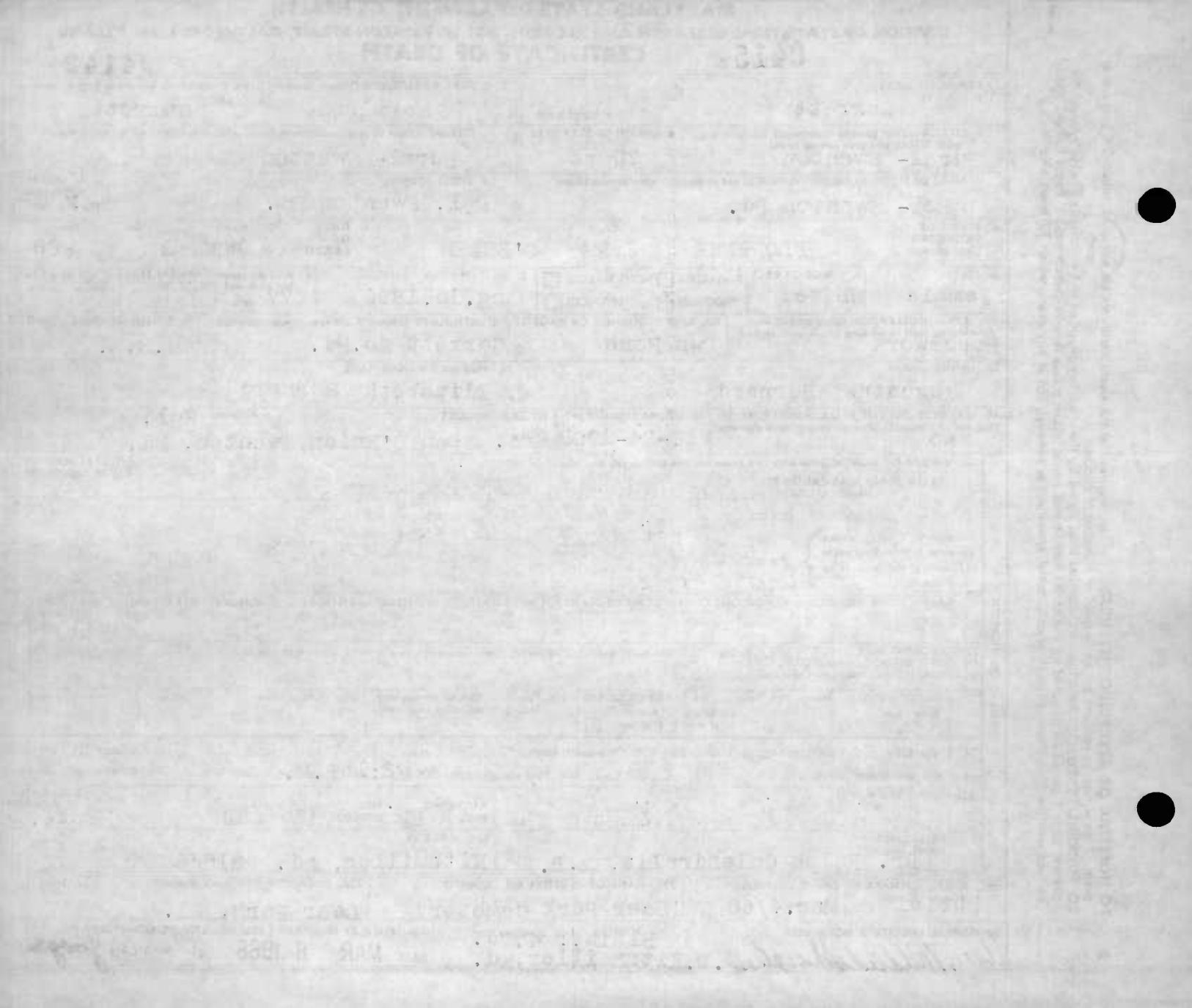
CERTIFICATE OF DEATH

04142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Swanton		c. LENGTH OF STAY IN 1b 70 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R#1 - Swanton Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE		First JANE	Middle O'BRIEN
4. DATE OF DEATH MARCH 1 1968		Last	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 15, 1890		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Garrett Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Augustus Bernard	
14. MOTHER'S MAIDEN NAME Elizabeth Bernard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) NO	
16. SOCIAL SECURITY NO. 212-24-1968		17. INFORMANT Mrs. Glen O'Brien, Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 404 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Hypertensive Drowning</i> DUE TO (c) <i>Cardiac - Vascula Renal Disease</i> <i>1/4 pint urine</i>		19. INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 443 X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to March 1968, that (I) (we) last saw the deceased alive on March 1 1968, and that death occurred at 2:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE <i>Ralph Calandrella</i> M.D.	
22c. PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D.		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Kitzmiller, Md. 21538	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 4/68	
23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery		23d. LOCATION (City, town or county) Deer Park, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Amy Mildred Shapley, O. Kitzmiller, Md.</i>		25a. REC'D BY REGISTRAR Blaine, W. Va. DATE MAR 6 1968	
25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

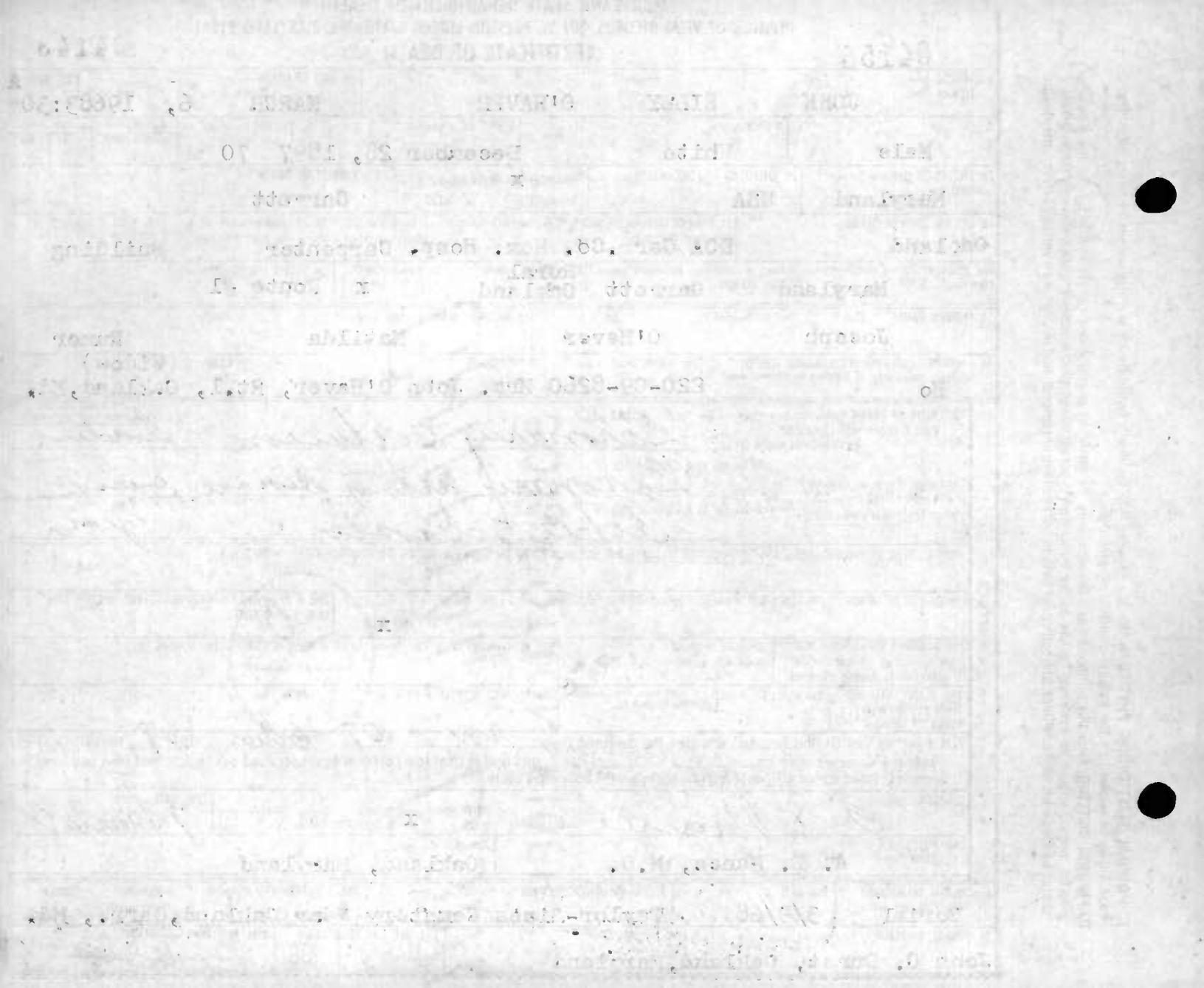
04143

04158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Lost	2. DATE OF DEATH Month	Day	Year	2b. HOUR A						
JOHN RILEY O'HAVER						MARCH	6,	1968	3:30M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male		White		December 28, 1897 70 yrs.		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Garrett		Oakland		DOA Garr. Co. Mem. Hosp. Carpenter		Carpenter		Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
STATE Maryland		Garrett		First Joseph Middle O'Haver Lost		First Matilda Middle Rumer Lost		No		220-09-8260		Mrs. John O'Haver, Rt. 1, Oakland, Md.		(Widow)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> <i>Coronary Occlusion</i> <i>4 days</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary artery disease</i> <i>years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> <i>years</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
4201						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1967</i> to <i>Feb 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 29 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>A. E. Mance</i>		22c. DATE SIGNED <i>7 Mar 68</i>		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS A. E. Mance, M.D. Oakland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/9/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Taylor-Sines Cemetery</i>		23d. LOCATION (City or Town) Near Oakland, Garr., Md.		(County)		(State)					
24. FUNERAL DIRECTOR <i>John O. Durst</i>		ADDRESS <i>John O. Durst, Oakland, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jagger</i>									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04159

04144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Myrtle	Middle Naomi	Lost Robinette	2a. DATE OF DEATH Month 3	Day 26	Year 68	2b. HOUR 3:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Feb. 22, 1892		6. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0
7. BIRTHPLACE (State or foreign country) Garrett Co. Md.	8. CITIZEN OF WHAT COUNTRY? U.S.A.	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	10. CITY OR TOWN OF DEATH Oakland, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Garrett Co. Md.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.	13b. COUNTY Moorefield	13c. CITY OR TOWN Moorefield	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box # 422			
14. FATHER'S NAME First John	Middle T.	Last Grove	15. MOTHER'S MAIDEN NAME First Mary	Middle 	Last Dawson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 	17. INFORMANT Mrs. Landon Vetter (Daughter)	Address Oakland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) arteriosclerotic Cardiovascular APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) Disease years last. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4221							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan. 17, 1968 , to March 26, 1968 , that (I) (we) last saw the deceased alive on March 26, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. E. Mance M.D.		DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 26 Mar 68		
22d. PHYSICIAN'S NAME (Type) Dr. A. E. Mance (MD)		22e. ADDRESS Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (check)		23b. DATE 3-29-68	23c. NAME OF CEMETERY OR CEMETORY Olivet		23d. LOCATION (City or Town) Moorefield	(County) Hanover Co. Md.	(State) Md.
24. FUNERAL DIRECTOR Earl B. Thrush		ADDRESS Moorefield, W. Va.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	DATE MAR 29 1968	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04145

04160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Cecilia	Middle - - -	Last Ross	2a. DATE OF DEATH Month March	Day 24	Year 1968	2b. HOUR 7:30 a.m.
3. SEX Female		4. RACE White	5. DATE OF BIRTH April 9, 1892		6. AGE (In years last birthday) 75		IF UNDER 1 YEAR MONTHS 0	
7a. BIRTHPLACE (State or foreign country) Selbysport, Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Garrett		IF UNDER 24 HRS. MONTHS 0	
10. CITY OR TOWN OF DEATH Friendsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) none			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Garrett	13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER		
14. FATHER'S NAME First George		Middle Wolf	Last Frazee	15. MOTHER'S MAIDEN NAME First Adelie		Middle 	Last Vanhorn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-12-2091		17. INFORMANT A. Donal Frazee		Address Selbysport, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma								Months
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> 153.8								Months
(b) Primary carcinoma of colon								Months
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 153.8								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1963 , 19 19 , to 3-12-68 , 19 19 , that (I) (me) last saw the deceased alive on 3-12-68 , 19 19 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (me) (did) (me) view the body after death.								
22b. SIGNATURE <i>James H. Feaster, Jr., M.D.</i>								22c. DATE SIGNED 3-24-68
22d. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M.D.		22e. ADDRESS 104 S. 2nd. St., Oakland, Md. 21550						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/68	23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cemetery		23d. LOCATION (City or Town) Grantsville		(County) Maryland	
24. FUNERAL DIRECTOR Gerald N. Minnich		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR APR 1 - 1968		25b. REGISTRAR'S SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04161

Item 6 Film G399 3/29/68 kk

CERTIFICATE OF DEATH

04146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Edith	Middle May	Last Shaffer	2a. DATE OF DEATH Month March	2b. HOUR Day 19 Year 68 8:50AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 10, 1894		6. AGE (In years at birthday 73 14 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Horseshoe Run, W. Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett Co. Md.		
10. CITY OR TOWN OF DEATH Oakland, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.	13b. COUNTY Preston	13c. CITY OR TOWN Horseshoe Run	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Horseshoe Run, W. Va.	
14. FATHER'S NAME Edward	Middle Winters	15. MOTHER'S MAIDEN NAME Matilda	Last Roth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17. INFORMANT William Shaffer (Husband)	Address Horseshoe Run, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> — DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>March 19, 1968</i> , to <i>March 19, 1968</i> , that (I) (we) lost saw the deceased alive on <i>March 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Herbert J. Leighton</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 19 Mar 68	
22d. PHYSICIAN'S NAME (Type) Dr. Herbert Leighton, MD	22e. ADDRESS Oakland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 22, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Texas Cemetery	23d. LOCATION (City or Town) Horse Shoe Run, W. Va.	(County)	(State)
24. FUNERAL DIRECTOR Davis, W. Va.	ADDRESS		25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04162

04147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	3	Doy	Year	2b. HOUR
Angela Laura				TICHINELL	MARCH	3	1968	7:47 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 3, 1968		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED WIDOWED		9. COUNTY OF DEATH GARRETT COUNTY			
10. CITY OR TOWN OF DEATH OAKLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT CO. MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY GARRETT		13c. CITY OR TOWN SWANTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ROUTE # 1	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Last
					MARGARET		LAURA		TICHINELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		RT. 1.	
				HAGAN D. Tichinell		Swanton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>7701</u> <u>Atelectasis - Respiratory Failure</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>5 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>7615</u> <u>Cerebral Anoxia</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Partial Abruptio Placenta.</u> (b) <u>7615</u> <u>Cerebral Anoxia</u> (c) <u>Partial Abruptio Placenta.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
<u>Prematurity - 7 month gestation - (3 lb 11 oz Birth Wt.)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 3, 1968, to MARCH 3, 1968, that (I) (we) last saw the deceased alive and <u>March 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Herbert H. Leighton</u>		22c. DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 3 Mar 68	
22d. PHYSICIAN'S NAME (Type) DR. HERBERT LEIGHTON		22e. ADDRESS		OAKLAND, MARYLAND 21550					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/4/68		23c. NAME OF CEMETERY OR CREMATORIAL Turner Cem.		23d. LOCATION (City or Town) Swanton		(County) Garrett Co., Md. (State)	
24. FUNERAL DIRECTOR J. Boal		ADDRESS Westernport, Md.		25a. REG'D BY REGISTRAR MAR 3 1968		25b. REGISTRAR'S SIGNATURE Garrett Co., Md.		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04163

CERTIFICATE OF DEATH

04148

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First David	Middle William	Lost Walter	2a. DATE OF DEATH Month 3	Doy 23	Year 68	2b. HOUR AM 8:20 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 29, 90			6. AGE (In years lost birthday) 77	YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Oakland, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett Co.		
10. CITY OR TOWN OF DEATH Oakland, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Telegrapher			12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Oakland, Md.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 316 S. Sixth St.				
14. FATHER'S NAME First Lewis	Middle Walter	15. MOTHER'S MAIDEN NAME First Ella	Middle Little					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) A-678509	17. INFORMANT Ellen Turney (Neice)	Address Oakland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c) and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>890X</u> BETWEEN ONSET AND DEATH <u>26 hrs</u> (b) <u>Smoke Inhalation (accidental)</u> (c) <u>Coronary Artery Disease</u> <u>years</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hyperensive Cardi-vascular Disease and Diabetes Mellitus</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Doy Year 5:30 A.M. 3 22 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Smoke Inhalation House fire</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>Home</u>	21f. LOCATION Street or R.F.D. No. <u>Garrett Co.</u>	City or Town <u>Oakland</u>	County <u>Garrett</u>	State <u>Md.</u>			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>March 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A. E. Mance</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 23 Mar 68				
22d. PHYSICIAN'S NAME (Type) Dr. A. E. Mance (MD)	22e. ADDRESS Oakland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/26/68	23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	23d. LOCATION (City or Town) Oakland	(County) Maryland	(State)			
24. FUNERAL DIRECTOR <u>Gerald N. Minnick</u>	ADDRESS Oakland, Maryland	25a. REC'D BY REGISTRAR APR 1 - 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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04164				04149			
1. DECEASED-NAME (Type or print)		First GEORGE	Middle WILLIAM	Lost	2a. DATE OF DEATH Month MARCH		2b. HOUR 8 Day 1968 5:10 P.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 18, 1886		6. AGE (In years last birthday) 81 1/2 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH GARRETT	
10. CITY OR TOWN OF DEATH OAKLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT COUNTY MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming		12b. KIND OF BUSINESS OR INDUSTRY FARMER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY GARRETT		13c. CITY OR TOWN Accident MILLION		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER P.O. BOX # 23
14. FATHER'S NAME First HENRY		Middle W.	Lost	15. MOTHER'S MAIDEN NAME First FANNIE		Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 215-36-9753		17. INFORMANT Everett Weitzell		Address Riverdale, Maryland	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) 2029 <i>Sympathina</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ten to ten</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.</p> <p>(b) <i>athetosclerosis</i> —</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>—</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>2021</p>							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
							State
<p>22a. I certify that (I) (this hospital) attended the deceased from FEB. 11, 1968 to MARCH 8, 1968, that (I) (we) last saw the deceased alive on MARCH 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> <p>22b. SIGNATURE <i>A. E. Mance, M.D.</i></p> <p>22c. DATE SIGNED 8 Haw 68</p>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
A. E. MANCE, M.D.		OAKLAND, MARYLAND 21550					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/10/68		23c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery		23d. LOCATION (City or Town) (County) (State) Deer Park, Maryland	
24. FUNERAL DIRECTOR <i>Gerald D. Minich</i>		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

04150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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04165

1. DECEASED-NAME (Type or print)	First Bura	Middle Margaret	Lost Wilson	2a. DATE OF DEATH Month March	Day 2	Year 1968	2b. HOUR 5:45 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 18, 1886		6. AGE (In years last birthday) 81	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett County, Md.				
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Swanton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Route # 1			
14. FATHER'S NAME William Curry Tichnell	15. MOTHER'S MAIDEN NAME Ellen		Middle		Last Paugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Riley Wilson	Address Swanton, Md.				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mrs			
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i>				yes			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>				41.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201							
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 1967, to March 2, 1968, that (I) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>B. L. Grant</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-3-68		
22d. PHYSICIAN'S NAME (Type) Dr. B. L. Grant	22e. ADDRESS Oakland, Maryland 21550						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/5/68	23c. NAME OF CEMETERY OR CREMATORIUM Tichnell		23d. LOCATION (City or Town) Swanton	(County) Garrett	(State) Md.	
24. FUNERAL DIRECTOR <i>J. Bura</i>	ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

